Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD0069	A. BUILDING _____ B. WING _____	04/06/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN'S COMMUNITY SERVICES	4434 SPRINGDALE ST NW WASHINGTON, DC 20016

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I 000	INITIAL COMMENTS A relicensure survey was conducted on April 4, 2007 through April 5, 2007. Two residents were randomly selected for the sample from a residential population of four females with varying degrees of mental retardation. The findings of the survey were based on observations at the group home, interviews with the clients, day program staff and residential staff, the review of clinical and administrative records and the review of the facility's unusual incident reports. Interview with the Qualified Mental Retardation Professional at 8:40 AM indicated that the GHMRP is participates in the waiver program.	I 000		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Observation of the bathrooms during the environmental rounds with the house manager and the QMRP on April 6, 2007 revealed that no cup dispensers were available.	I 082	Cup dispensers will be installed in all bathrooms	4/25/07
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.	I 090		

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Precious M Brown Director CLS-DC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 4/5/07

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1090	Continued From page 1 This Statute is not met as evidenced by: During the environmental observations at the GHMRP at 3:50 PM, the following concerns were identified. A. Exterior of the facility: 1. Heavily scaling paint was observed on the side of the house at the left of the deck, when exiting from the bedroom of Residents #1 and #4. 2. Heavily scaling paint was on the front house below the window which was above the garage. 3. Heavily scaling paint was on the wood underneath the gutter on the back of the house. 4. A section of the fence at the right corner of the yard was broken down and was not secured to the adjacent section of the fence. 5. An insufficient number of storage cans were availabe for trash collection. Interview with the QMRP indicated that trash is collected twice a week. One super trash can was observed to have the hinge broken causing the lid to be separated from the can. There was a hole in the lid of one trash can. A bag of trash was observed protruding above the top of one trash can. This caused the lid to remain in an open position. 6. The pavement was uneven where the two sections near the front porch meet. One of the four clients residing in the facility has ambulation difficulty and to requires the use of a rollator walker for safe mobility. 7. Exterior lights were not operable in the following locations:	1090	A. 1. Scaling will be completed on side of the house 2. The side of the house will be repainted 3. The scaling paint on the wood under the gutter will be repainted 4. Fence will be repaired 5. New storage can will be purchased 6. The two sections in front of the porch will be repaved 7. New light bulbs will be purchased for exterior lights	4/25/07

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I 090	Continued From page 2 a. At the exit door from the first floor sitting room. b. At the exit door from the kitchen. The switch to activate the light could not be located. Interview with staff revealed that it was probably behind or beside the refrigerator. The limited spaced between the wall and the refrigerator did not permit a switch to be visible or reachable. c. Basement entrance door. B. Interior of the facility: 1. The binding was missing from the edges of the rug on the floor in the rear bedroom. These edges of the rug were frayed. The corners of the rug were rolled upward, which created a potential trip hazard. 2. Items were stored directly on the floor of the linen closet. 3. Numerous brown spots were on the ceiling of the kitchen. Interview with staff indicated the origin of the stains was unknown. 4. The light bulb in one of the lamps in the living room was hanging downward, instead of being in a upright position.. 5. Mildew was on the grout between the tiles on the wall of the shower in the bedroom of Residents #1 and #4. Mildew was also on the caulking of the bath tub in the bathroom located off the hallway. 6. The wall beside the door of the basement bathroom was wet in an area extending approximately twelve (12) inches from the floor upward, and extending approximately two feet,	I 090	B. 1. New rug will be purchased for room in rear bedroom 2. Items have been removed from floor in linen closet 3. Brown spots will be removed form kitchen ceiling 4. Light bulb in the living room lamp will be fixed 5. Mildew will be removed from the tiles, shower, and bathtub 6. The damp wall in the basement will be repaired	

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I 090	Continued From page 3 from the right side of the bathroom door to the door of the garage. Mildew was also on the paneling attached to the wet wall. Interview with the QMRP indicated that she was not aware of the source of the dampness on the wall.	I 090		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: On April 6, 2007, interview with the Qualified Mental Retardation Professional and the review of the weekly staffing schedule indicated that there were the following shifts: a. Evening shift - Weekdays: 2:00 PM - 12:00 AM. b. Night shift - Weekdays: 12:00 AM - 10:00 AM. c. Home Manager/Trained Medication Employee : 7:00 AM to 3:00 PM. (Monday through Friday) d. Saturdays: 1 staff 12:00 AM - 10:00 AM; 1 staff 10:00 AM - 4:00 PM; 1 staff 10:00 AM - 10 PM, 1 staff 4:00 PM - 12:00 AM e. Sundays: 1 staff 12:00 AM - 12:00 PM; 1 staff 4:00 PM - 12:00 AM; 1 staff 12:00 PM - 12:00 AM and 1 staff 8:00 AM - 4:00 PM. Record review revealed the GHMRP had conducted numerous fire drill . The review of the drill record indicated that no time of day was documented on the drill held on July 24, 2006 and August 18, 2006. The review of the ten fire	I 135	Staff will be in-serviced on documenting fire drills	5/18/07

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I 135	Continued From page 4 drill conducted between June 8, 2006 and August 27, 2006, revealed no evidence fire drills were held during the eleven hour period between 7:00 AM and 6:30 PM on weekdays or weekends. Interview with the GHMRP indicated that the reason no drills were documented was that the GHMRP only had two shifts and no one was home during the day on weekdays. According to the fire drill schedule for 2006 and 2007, drills were scheduled to be held on the evening and night shifts during weekdays and on any shift during the daytime hours on the weekend. Further review of the fire drill records revealed there was no evidence that a simulated fire drill had been conducted at least four times a year for each shift of duty.	I 135		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: The review of the GHMRP's records for employees revealed no evidence the supervisor had discussed the contents of the job description with six of seven employees at least annually as detailed below: a. Three direct care staff (#1, #2, #3, #4) b. The Qualified Mental Retardation Professional (Staff #6) c. The residential coordinator had been promoted from her original duties as a direct care staff. There was no job description to outline the client's current responsibilities. (Staff #5)	I 203	All staff has signed their job descriptions. In the future the Program Director will ensure that job descriptions are signed on an annual basis for all employees.	4/25/07

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I 203	Continued From page 5 d. The LPN assigned to the GHMRP (Staff #7)	I 203		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: The review of staff and consultant records on April 6, 2007 revealed the GHMRP failed to maintain certification that a health inventory had been performed for each employee and verify that their health status would allow them to perform the required duties. No current health certificates were available for the podiatrist and Staff #2.	I 206	Current physical is on file for the Podiatrist date 10/27/06 A letter has been sent to staff requesting the need for the current health certificate	4/25/07
I 226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: Each training program shall include but not be limited to the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This statute is not met as evidenced by:	I 226		

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I 226	Continued From page 6 Record review on April 6, 2007 revealed a CPR card for the Qualified Mental Retardation Professional (QMRP) which had an expiration date of March 17, 2007. Interview with QMRP indicated that she had a current CPR card. At the time of the survey the current CPR card was not available for review.	I 226	Current CPR card on file for QMRP	4/25/07
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: The GHMRP failed to ensure that each employee received annual training in the following areas: Interview with the Qualified Mental Retardation Professional and the review of records on April 6, 2007 revealed the staff had received training within the last twelve months in the following areas: 1. Dental health 2. Human development	I 229	Staff will be trained on Dental Health and Human Development.	5/18/07
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially	I 379		

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I 379	Continued From page 7 interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Interview with the residence manager on April 5, 2007 revealed there had been no unusual incidents since the last survey. Further interview with the residence manager however, revealed that Client # 3 was treated at the emergency room on November 16, 2006 for a right forearm abscess. Record review revealed an incision was made to drain the abscess and the client was treated and released. Keflex 500 mg Q 6 hours was prescribed for seven days to treat the infection. There was no evidence the unusual incident was reported to the Department of Health as required by state law.	I 379	Staff will be retrained on incident reporting	5/18/07
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: The facility failed to ensure professional services for two of two residents in the sample.(Residents #1 and #2) 1. Resident #2 had a annual physical	I 401		

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I 401	Continued From page 8 examination on June12, 2006. The primary care physician (PCP recommended that a lipid profile be conducted. The review of available data on April 5, 2007 revealed that no lab results were available for lipids. Interview with the LPN on April 5, 2007 at 1:15 PM indicated that the lipid profile had not been conducted. There was no evidence the lipid profile and been provided for Resident #2 as recommended by the PCP. 2. The GHMRP failed to ensure that Resident #2 received health services for the maintenance of her dental health as detailed below: a. Resident #2 had a dental recall on July 19, 2006 during which the dentist indicated "Recall exam, heavy calculus; needs scaling". Under the recommendation section, the dentist indicated "We have stopped treating patients with this insurance until they reimburse us for previous treatment. Please call to discuss the details." It should be noted that the record reflected that Resident #2 received a dental scaling on September 15, 2005, however there was no evidence that the status of the mobile tooth #9 which was identified in the previous dental recall assessment (July 6, 2005) was ever addressed. Interview with the LPN on April 5, 2006 revealed the status of tooth #9 was unknown. Further interview with the LPN indicated the resident went to the dentist however, the dentist indicated that she was not being paid by the waiver program. There was no evidence the resident received dental treatment services in accordance with her assessed needs. b. The review of a nursing progress note dated July 20, 2006 indicated "Resident states sometimes she has pain in her gum. Made an appointment with the dentist. Will continue to	I 401	1. Lipid profile has been completed. In the future labs recommended by the Primary Care physician will be completed in a timely manner. 2. Residential Manager has scheduled another appointment for client #2. Alternative dental care is being explored by QMRP, Nurse and Case Manager b. In the future all prescription will be filled in a timely manner when the order is given by the Primary Care Physician	

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I 401	Continued From page 9 follow up." According to a nursing progress noted dated August 5, 2006, Resident #2 was assessed for gum swelling and the PCP was called. The PCP ordered that the resident be taken to the emergency room for evaluation. The ER did not treat the resident however, recommended that she be instead be evaluated by a dentist. The nurse telephoned the regular dentist and was informed that the dentist was on vacation. The PCP then prescribed Penicillin V 500 mg po BID for seven days. The review of the medication administration record and interview with the nurse indicated that the resident did not receive the first dose of the Penicillin V 500 mg until August 9, 2007, four days after the resident went to the ER. There was no evidence the resident received timely treatment to address her dental problem. 3. Resident #1 had an endocrinology follow-up consultation on December 14, 2006. A lipid panel was among the test recommended by the endocrinoligist. The endocrinology consultation report further indicated "I have no lab test since May 2005. During the last visit in December 2005, the patient was given a lab form." The endocrinologist recommended that the resident have a lipid panel. The review of available data on April 5, 2007 revealed that no lab results were available for lipids. Interview with the LPN on April 5, 2007 at 1:15 PM indicated that the lipid profile had not been conducted. There was no evidence the lipid profile and been provided for Resident #2 as recommended. 4. The review of Resident #1's physician's medication orders dated April 1, 2007 revealed "Acetaminophen/Cod Elixir 120/ml, take 1-2 teaspoonful by mouth every 4 hours as needed for pain. Interview with the LPN on April 6, 2007 regarding the prn order for the controlled	I 401	3. Lipid profile had been completed. In the future labs recommended by Endocrinologist will be completed in a timely manner 4.Acetaminophen/Cod elixir has been discontinued by Client #1 Primary Care Physician.. The updated order has been faxed to the pharmacy. Although the controlled substance was not in the house the house nurse will follow all established medical perimeters for dealing with a controlled substance.	4/25/07

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I 401	Continued From page 10 substance indicated the Resident had not received the medication since she was transferred to the GHMRP on August 22, 2006. Further record review however, failed to revealed evidence that medical parameters had been established for the use of the controlled substance (Codeine) for pain management.	I 401		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN	4815 CHESAPEAKE STREET, NW WASHINGTON, DC 20016

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{W 000}	INITIAL COMMENTS On June 19, 2007, a follow-up survey was conducted to verify compliance with the Condition of Client Protections previously determined to not be in compliance on May 11, 2007. The findings of the survey were based on observations at the group home and interviews with staff and clients, and the review of records including incident reports and administrative records. At the time of this revisit, the facility was found to be in substantial compliance in the areas of Client Protections with continued standard level deficiencies noted.	{W 000}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review during the re-visit conducted on May 11, 2007, the facility failed to ensure that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional. (QMRP) The findings include: 1. Review of the facility's June 16, 2007 Plan of Correction (POC), by June 1, 2007, the QMRP revised all necessary programs for proper implementation. At the time of the revisit, there was no evidence that the QMRP had made the revisions as indicated. Review of Client #1 and #2's objectives failed to evidence any revisions.	{W 159}	The QMRP completed the revisions as indicated. The QMRP reviewed the book and ensured that the items were filed properly. The Director of Community Living reviewed the goals.	7-10-07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Patricia Brown Director CLS DC 7/10/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 159}	Continued From page 1 2. Review of client #2's ISP record at 2:00 PM to verify goals and objectives evidence an expired May 2006 Individual Support Plan (ISP) and Individual Program Plan (IPP). According to the House Manager, a new ISP meeting had been held recently (date unknown), however, during a recent court hearing, the Judge gave the facility a 30 day extension for the QMRP and the DDS case manager to complete the document. 3. Cross refer to W249. Review of the June 16, 2007 Plan of Correction revealed that the facility nurse had reviewed the individualized program plans for all of the individuals to ensure proper implementation of self medication programs. Interview with the morning medication nurse on June 19, 2007 at 7:40 AM revealed that the self-medication programs had not been revised. It was further indicated that the current programs in place were not appropriate due to changes in health status and physical limitation. At the time of the survey, there was no evidence that the QMRP had coordinated with the facility nurse for appropriate program revisions and was consistently monitoring the clients progress. Formal assessments were not made available at the time of the revisit to verify individual strength and needs. There was no evidence that the QMRP had revised each clients program to meet their individual need and level of participation. 4. Review of the June 16, 2007 POC, Client #2's splint had been ordered. Observations throughout the revisit on June 19, 2007, client #2 was not observed wearing the splint. On June 19, 2007 at 2:15 PM a review of Client #2's record was completed for verification. Two different OT assessments were reviewed. On	{W 159}	2, The current ISP was completed on June 29, 2007 in accordance with the judges orders regarding the dates; and filed with DDS. 3. The QMRP and the Nurse reviewed the self-medication goals and the appropriate actions were implemented in accordance with their specific needs. 4, The QMRP will investigate the discrepancies further with the OT to provide written documentation to add to the plan of care.	7-6-2007 7-10-2007 7-10-2007

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G173	A. BUILDING _____ B. WING _____	R 06/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{W 159}	Continued From page 2 May 20, 2006 the OT recommended client #2 could benefit from the use of a splint. However on October 20, 2006 an annual re-assessment was completed, that did not state the continued benefit of the splint. A review was conducted of the QMRP monthly and quarterly monitoring notes and this there was no evidence that the discrepancies in needs and benefits of the splint had been clarified. Interview with the House Manager at 2:45 PM revealed that the necessary medical form had been completed and submitted to obtain the splint, however, was unable to provide the necessary documentation for verification.	{W 159}		
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing for one of two clients in the sample. (Client #2) The finding includes: Interview with the House manager on June 19, 2007 at approximately 2:45 PM, revealed that Client #2 has a diagnosis of diabetes. Once a week on Mondays, her blood glucose is check by the medication nurse utilizing an Accu-Check machine. The medication nurse records the glucose level on the medication administration record, with orders to notify the RN if blood glucose levels are less than 60 or greater than	W 393	The Agency is currently in the process of addressing the Certificate of Waiver. If an certificate is not on file then the agency will submit an application for a waiver within 30 days.	7-10-2007

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W 393	Continued From page 3 160. The House Manager revealed that the provider did not have a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA) to perform laboratory services, such as glucose monitoring in the facility. This information will be referred to the laboratory surveyor for review.	W 393		
{W 436}	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients were provided with necessary adaptive equipment, for one of the two clients (Client #2) included in the sample. The finding includes: Review of the June 16, 2007 Plan Of Correction (POC), revealed Client #2's splint had been ordered. Observations throughout the revisit on June 19, 2007, client #2 was not observed wearing the splint. Interview with the House Manager at 2:45 PM revealed that the necessary medical form had been completed and submitted to obtain the splint, however, was unable to provide the	{W 436}	The splint was ordered and obtained however the QMRP is discussing the needs of the splint with the OT. See. W. 159.	7-10-2007

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{W 436}	Continued From page 4 necessary documentation for verification.	{W 436}		